Germany's statutory health insurance scheme: past developments and future challenges

Approximately 85% of the population in Germany are insured under the statutory health insurance scheme. With expenditure of almost €200 billion, it is the second largest component of the social security system after the statutory pension insurance scheme. Over the past decade, its expenditure growth has clearly outpaced that of the other major branches of the social security system, thereby necessitating frequent amendments to benefits legislation. As income subject to contributions grew more slowly than expenditure, the contribution rate had to be raised significantly and central government was additionally obliged to make substantial transfers. As both the individual health insurance institutions and the central health insurance fund currently hold large reserves, the statutory health insurance scheme appears to be in a comfortable financial situation at present. However, this trend has already gone into reverse. The scheme is already likely to record deficits and deplete its financial reserves this year. If expenditure growth remains strong, contribution rates will have to rise further.

The statutory health insurance scheme is highly complex and incorporates numerous powerful interest groups. Although fundamental reforms were discussed in recent years, only gradual changes were actually made. There is still scope for increasing efficiency as well as making the distribution mechanisms more transparent and focused. It would be better, for example, if income redistribution objectives were to be concentrated more within the governments' taxation and transfer systems and if central government grants were clearly earmarked for specific non-insurance-related benefits. Moreover, the system's cost-effectiveness could be enhanced through greater transparency regarding both costs for patients and the therapeutic value of available benefits as well as through higher co-payments by insurees. Legislative intervention will likewise continue to be required in order to keep cost pressures in the healthcare system in check. Given foreseeable demographic changes, the scheme's funding base will also have to be stabilised by increasing labour force participation. Raising the statutory retirement age in line with longer life expectancy would also help, but expanding the options for taking early retirement would be counterproductive.

Salient features of the statutory health insurance scheme

Statutory health insurance scheme predominant in Germany

In 2013, the statutory health insurance system *(gesetzliche Krankenversicherung)* comprised 134 health insurance institutions[1] and just over 52 million members, of whom around 36 million were of working age and overwhelmingly employees and 16½ million were pensioners. Including their co-insured dependants (who are exempt from contributions), a total of 70 million people were insured under the statutory scheme.[2] It is chiefly employees earning up to €4,462.50 gross per month (harmonised compulsory insurance limit for both eastern and western Germany) that are compulsorily insured under the statutory health insurance scheme.[3] If employees earn more than this, they can opt either to be insured voluntarily under the statutory health insurance scheme or to switch to the private health insurance system (see the box on pages 34 and 35).

Funding via income-related contributions in pay-as-you-go system

The statutory health insurance scheme is mostly funded (93% in 2013) from income-related percentage contributions up to the income cap for contributions (currently €4,050 per month). The remainder mostly comes from central government grants (6%), which have been considerably topped up since 2004 but which are often changed on a discretionary basis. The statutory health insurance scheme is essentially funded via a pay-as-you-go system, in other words current revenue is used directly to cover current expenditure. Reserves are legally required solely for the purpose of offsetting short-term fluctuations in revenue and expenditure. Borrowing is not permitted.

Funding system switched to central health insurance fund

Since the introduction of a central "health insurance fund" in 2009, health insurance institutions no longer receive contribution receipts and central government grants directly but instead receive them indirectly from the fund in the form of a risk-adjusted amount for each member. Instead of each institution being able to set its own contribution rate – as was previously the case – they were bound by law to levy a uniform rate of, initially, 15.5%. Health insurance institutions must currently plug any funding gaps by charging their members a flat-rate additional contribution. However, following a recent legislative amendment, additional contributions must be calculated on an income-related basis from 2015 onwards.

Risk structure compensation scheme essential to ensure competition between institutions

The statutory health insurance institutions are compelled to accept everyone who applies to join, regardless of his/her individual health risks.[4] A risk structure compensation scheme exists to enable risks to be shared between health insurance institutions with below-average and those with above-average health risks, thus discouraging institutions from adopting a risk selection policy and thereby promoting competition by allowing members to switch institutions irrespective of their state of health.

Benefits legally prescribed; non-financial benefits predominant

The benefits offered by the statutory health insurance scheme are basically defined in the Fifth Book of the Social Security Code. In addition to treating illnesses, these also include preventive and screening measures, medical rehabilitation, antenatal and postnatal care as well as the payment of sickness benefit. The concrete implementation of the legal provisions is agreed, for the most part, by the Federal Joint Committee comprising representatives of the service providers and the health insurance institutions. Directives issued by this Committee specify which treatments or examinations persons insured under the statutory health insurance scheme

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1 In 2003, there were 324 health insurance institutions, down from 1,223 in 1992.
2 Private health insurance enterprises had approximately nine million fully insured members in 2012.
3 The level of contributions to be paid by compulsorily insured employees is based on their gross wage or salary. Pensioners pay contributions based on their state or company pension. There are special provisions for the unemployed, sailors, artists and publicists, young people and disabled persons in institutions as well as for students and interns. The level of contributions to be paid by voluntarily insured members of the statutory scheme is determined by means of a uniform assessment which may not be lower than for compulsorily insured members. Self-employed persons must normally pay contributions at the level of the income cap for contributions; if they can demonstrate that their income is lower than this, they generally pay at least three-quarters of that rate (sections 226 ff of the Fifth Book of the Social Security Code).
4 There are, however, restrictions regarding the admission of persons who were hitherto privately insured.

Key data on the statutory health insurance scheme

Item	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2013 vis-à-vis 2003
Contribution base in € billion[1]	965	969	976	989	1,019	1,028	1,049	1,073	1,112	1,150	–
Contribution base in € per member per year	19,054	19,230	19,339	19,487	19,941	20,066	20,414	20,800	21,373	21,930	–
Members (million)	50.6	50.4	50.5	50.7	51.1	51.2	51.4	51.6	52.0	52.4	–
of whom											–
Compulsorily insured persons	28.7	28.7	28.7	29.2	29.7	29.9	30.1	29.9	30.1	30.5	–
Voluntarily insured persons[2,3]	5.1	4.8	4.8	4.6	4.5	4.4	4.5	4.9	5.2	5.3	–
Pensioners[2,4]	16.8	16.9	16.9	16.9	16.9	16.9	16.8	16.8	16.8	16.7	–
Total insurees (million)	70.2	70.5	70.4	70.3	70.2	70.0	69.8	69.7	69.7	69.9	–
Contribution rate (%)[5]	14.2	14.2	14.2	14.8	14.9	15.2	14.9	15.5	15.5	15.5	–
Income cap for contributions (€ per month)	3,488	3,525	3,563	3,563	3,600	3,675	3,750	3,713	3,825	3,938	–
Compulsory insurance limit (€ per month)	3,863	3,900	3,938	3,975	4,013	4,050	4,163	4,125	4,238	4,350	–
Number of health insurance institutions	280	267	257	242	221	202	169	156	146	134	–
	Year-on-year percentage change										Annual
Contribution base	1.0	0.5	0.7	1.3	3.0	0.9	2.0	2.3	3.6	3.4	1.9
Contribution base per member	1.3	0.9	0.6	0.8	2.3	0.6	1.7	1.9	2.8	2.6	1.5
Members	– 0.3	– 0.4	0.1	0.5	0.7	0.3	0.3	0.4	0.9	0.7	0.3
of whom											
Compulsorily insured	– 0.7	– 0.2	0.2	1.5	1.7	0.9	0.5	– 0.6	0.8	1.1	0.5
Voluntarily insured[2,3]	– 1.1	– 4.8	– 0.8	– 3.2	– 2.8	– 1.1	0.3	10.3	5.2	2.6	0.4
Pensioners[2,4]	0.8	0.5	0.0	0.0	– 0.1	– 0.1	– 0.2	– 0.2	– 0.2	– 0.6	0.0
Total insurees	– 0.2	0.4	– 0.3	0.0	– 0.2	– 0.3	– 0.3	– 0.1	0.0	0.2	– 0.1
Contribution rate (percentage point)[5]	– 0.1	– 0.1	0.0	0.6	0.1	0.3	– 0.3	0.6	0.0	0.0	0.1
Income cap for contributions	1.1	1.1	1.1	0.0	1.1	2.1	2.0	– 1.0	3.0	2.9	1.3
Compulsory insurance limit	1.0	1.0	1.0	1.0	0.9	0.9	2.8	– 0.9	2.7	2.7	1.3
Number of health insurance institutions	– 13.6	– 4.6	– 3.7	– 5.8	– 8.7	– 8.6	– 16.3	– 7.7	– 6.4	– 8.2	– 8.5

Sources: Federal Ministry of Health, National Association of Statutory Health Insurance Funds and Bundesbank calculations. **1** Calculated from revenue from contributions and the average contribution rate. **2** As of mid-2004, voluntarily insured pensioners are assigned to voluntary members who are not entitled to sickness benefit. **3** General health insurance scheme (members excluding pensioners). **4** Pensioners' health insurance scheme. **5** Annual average. Up to and including 2008, average contribution rate for all health insurance institutions. As of 2009, excluding additional contributions.

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are entitled to. In most cases, the health insurance institutions invoice the service providers directly without involving the patients (principle of non-invoicing patients).

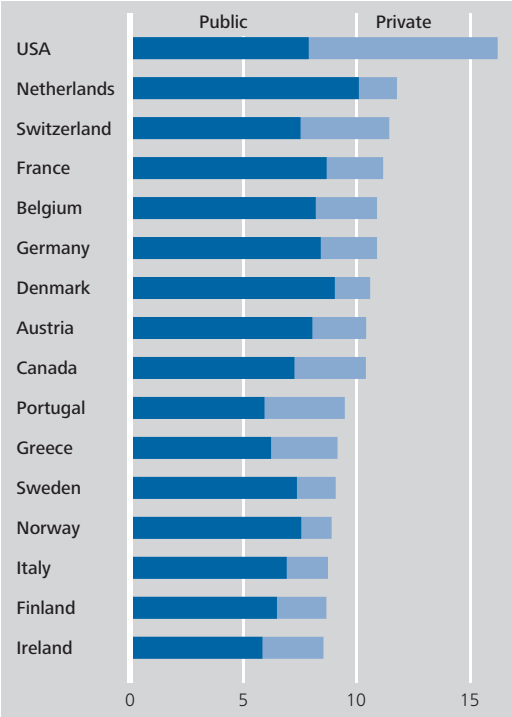
Redistribution principle

One of the key features of the statutory health insurance scheme is a risk-sharing mechanism between individuals with a low health risk and those with a higher health risk. Another mechanism redistributes income from higher to lower earners, from contribution payers to non-paying dependants and from households with few to those with more non-paying dependants. Unlike the statutory pension insurance scheme and the statutory unemployment insurance scheme (but as in the public long-term care insurance scheme), there is no direct peg between the relative level of contributions and the level of insurance entitlements.[5] Demographic change in Germany will gradually also bring about an intergenerational redistribution, not least because healthcare costs are typically higher for older persons. If the statutory retirement age is not raised in line with longer life expectancy, this alone (ie without factoring in costly advances in medical technology and factoring out the age-related graduation of healthcare costs) will

5 The one big exception to this is the level of sickness benefit, which is based on earnings, but this only makes up around 5% of total expenditure.

Healthcare expenditure in selected countries in 2012

As a percentage of GDP



Source: OECD Health Data 2014.
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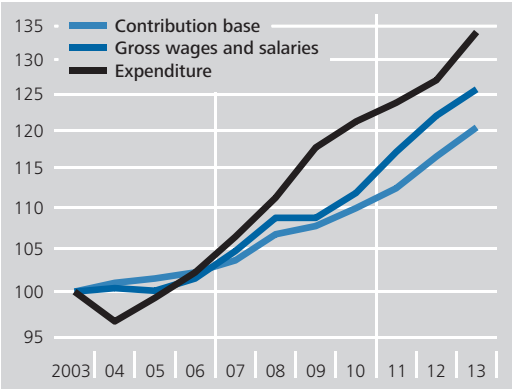
mean that the contribution rate will have to go up significantly as pensioner contributions do not suffice, on average, to cover their costs.

With an expenditure volume in 2013 of just over €194 billion, or just over 7% of gross domestic product (GDP), the statutory health insurance scheme is the second largest component of the German social security system after the statutory pension insurance scheme. According to OECD data, Germany's total public sector expenditure on healthcare (including spending by the public long-term care insurance scheme and healthcare subsidies for public sector employees with civil servant status) amounted to nearly 8½% of GDP in 2012. After adding the expenditure of private insurance enterprises as well as extra payments or co-payments made by patients themselves, total spending on healthcare amounted to almost 11% of GDP. In international terms, this makes Germany one of the highest healthcare spenders, slightly behind France (just over 11%), though way behind the USA (just over 16%).

Major macroeconomic importance of health insurance system also in international terms

Revenue base and expenditure of the statutory health insurance scheme

2003 = 100, log scale



Sources: Federal Ministry of Health (KJ1 statistics) and Bundesbank calculations.
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Basic trends over the past decade[6]

Financial development

The statutory health insurance scheme is currently in a relatively comfortable financial situation with total reserves of €30 billion at end-2013 (€16½ billion for the health insurance institutions and €13½ billion for the health insurance fund). This was further boosted last year by a surplus of €2 billion. By contrast, at the beginning of the period under review (end-2003), it had accumulated net debt of €6 billion after having recorded a deficit of €3½ billion in 2003.[7]

Current financial situation favourable

6 For trends prior to this date, see Deutsche Bundesbank, Financial development and outlook of the statutory health insurance scheme, Monthly Report, July 2004, pp 15 ff.
7 Although the health insurance institutions are not permitted to borrow, after a series of inaccurate (overly optimistic) forecasts of expenditure and revenue, they were forced to take out a loan to temporarily cover the resultant funding gaps. The Act Modernising the Statutory Health Insurance Scheme, which came into force in 2004, retroactively legitimised the loan and, at the same time, prescribed that it be repaid in equal instalments over the next four years. The loan was repaid faster than expected, so there was no need to use the extension by one year that was envisaged as a precautionary measure in the Act Amending the Law Governing the Professional Activities of Doctors Approved by the Statutory Health Insurance Scheme.

Expenditure and revenue of the statutory health insurance scheme

€ billion

Item	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2013 vis-à-vis 2003
Revenue from contributions	140.1	140.3	142.2	150.0	155.9	158.7	160.8	170.9	176.4	182.2	–
Central government grant	1.0	2.5	4.2	2.5	2.5	7.2	15.7	15.3	14.0	11.5	–
Other revenue	3.2	3.0	3.5	3.6	4.1	4.0	3.0	2.9	2.9	2.7	–
Total revenue[1]	144.3	145.7	149.9	156.1	162.5	169.8	179.5	189.0	193.3	196.4	–
Expenditure on benefits	131.2	134.8	138.7	144.4	150.9	160.4	165.0	168.7	173.2	182.7	–
of which											
In-patient hospital treatment	47.6	49.0	50.3	50.9	52.6	56.0	56.7	58.5	60.2	62.9	–
Out-patient treatment	23.0	23.1	23.9	24.8	25.9	27.6	28.4	29.1	29.7	32.8	–
Dental treatment[2]	11.3	9.9	10.4	10.7	10.9	11.2	11.4	11.7	11.7	12.6	–
Pharmaceuticals[3]	21.8	25.4	25.8	27.8	29.1	30.7	30.1	28.9	29.2	30.1	–
Therapeutic treatment and aids	8.3	8.3	8.3	8.7	9.1	9.6	10.6	11.2	11.5	12.1	–
Rehabilitation	2.4	2.4	2.3	2.5	2.5	2.4	2.4	2.4	2.4	2.5	–
Transportation expenses	2.6	2.8	2.9	3.0	3.3	3.5	3.6	3.8	4.0	4.3	–
Sickness benefit	6.4	5.9	5.7	6.0	6.6	7.3	7.8	8.5	9.2	9.8	–
Administrative costs	8.2	8.3	8.3	8.5	8.7	8.9	9.6	9.5	9.7	10.0	–
Other expenditure	0.9	0.9	1.3	1.4	1.8	1.5	1.3	1.4	1.4	1.8	–
Total expenditure	140.3	144.1	148.3	154.3	161.3	170.8	175.8	179.6	184.3	194.5	–
Balance of revenue and expenditure	4.0	1.7	1.6	1.7	1.2	– 1.0	3.7	9.4	9.0	1.9	–
	Year-on-year percentage change										Annual
Revenue from contributions	1.3	0.1	1.4	5.5	3.9	1.8	1.3	6.3	3.2	3.3	2.8
Other revenue	39.1	– 5.3	18.5	1.3	15.0	– 3.8	– 23.7	– 5.2	1.8	– 6.8	1.8
Total revenue	1.9	1.0	2.9	4.1	4.1	4.5	5.7	5.3	2.3	1.6	3.3
Expenditure on benefits	– 3.7	2.8	2.8	4.1	4.5	6.3	2.8	2.3	2.6	5.5	3.0
of which											
In-patient hospital treatment	1.7	2.9	2.8	1.0	3.5	6.4	1.3	3.2	2.8	4.5	3.0
Out-patient treatment	– 5.5	0.6	3.5	3.7	4.4	6.8	2.9	2.2	2.2	10.5	3.0
Dental treatment[2]	– 4.7	– 11.9	4.4	3.1	2.2	2.7	1.8	2.0	0.8	7.4	0.7
Pharmaceuticals[3]	– 9.9	16.3	1.9	7.6	4.9	5.3	– 1.8	– 4.0	0.8	3.1	2.2
Therapeutic treatment and aids	– 12.0	0.0	0.2	4.7	4.6	5.3	10.8	5.5	2.5	5.3	2.5
Rehabilitation	– 6.6	– 1.0	– 1.6	5.0	1.2	– 1.7	– 1.9	– 1.5	2.8	3.5	– 0.2
Transportation expenses	– 8.7	8.8	2.6	4.4	7.1	7.5	2.9	5.7	5.2	8.4	4.3
Sickness benefit	– 8.7	– 7.8	– 2.7	5.4	9.4	10.2	7.4	9.4	7.5	6.4	3.4
Administrative costs	– 0.1	1.3	0.2	1.8	2.5	3.1	6.8	– 0.7	2.4	2.8	2.0
Total expenditure	– 3.3	2.7	2.9	4.1	4.5	5.9	2.9	2.2	2.6	5.6	3.0

Sources: Federal Ministry of Health, final annual outturn (KJ1 statistics) and Bundesbank calculations. **1** Excluding payments under the risk structure compensation scheme. **2** Including dentures. **3** Pharmaceuticals from pharmacies and other sources.

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Growth in expenditure curbed by government intervention

Over the past decade – as before that and no doubt in the future as well – the expenditure trend has largely been shaped by legislative changes. The intention behind most of these government interventions was to curb expenditure. One major example of such intervention was the Act Modernising the Statutory Health Insurance Scheme, which was adopted in 2003 and involved limiting the range of benefits, increasing patient co-payments and introducing a surgery visit charge. Furthermore, mandatory discounts levied on the manufacturers of pharmaceuticals were repeatedly raised for a temporary period. Overall, expenditure rose at an average rate of 3% per annum (both in total and per insuree). As a percentage of GDP, expenditure of the statutory health insurance scheme rose from 6¾% in 2003 to just over 7% in 2013. However, expenditure went up from just over 15% to almost 17% relative to employees' and pensioners' income subject to contributions (contribution base).

Sharp growth in revenue due to larger central government grants and higher contribution rates

At an average annual rate of almost 3½%, revenue grew somewhat faster than expenditure. Although central government grants were introduced in 2004 and have been increasing considerably overall since then (2013: €11½ billion, or 1% of the contribution base), higher contribution rates were still needed to offset

Relationship between statutory and private health insurance schemes

People insured under the statutory health insurance scheme can switch to a private health insurance scheme if their annual income exceeds the compulsory insurance limit or if their employment situation means they are no longer subject to social security contributions. It is possible to return to the statutory health insurance scheme if a person's individual income falls back below this limit. In such a case, there is a one-off (and irrevocable) option to remain privately insured. However, over-55s can no longer switch to the statutory health insurance scheme if they have not held statutory insurance in the preceding five years. This rule is intended to make it difficult for privately insured persons who have not participated for some time in the pay-as-you-go financing system within the statutory health insurance scheme to return to the scheme.

Unlike the pay-as-you-go statutory health insurance scheme, the funding model of the private health insurers is additionally based on capital cover. Younger members pay a contribution in excess of their current average healthcare costs. In this way, a reserve is built up which is then gradually reversed in old age if the member's ongoing contribution no longer covers his or her healthcare costs at that time. Nevertheless, an increase in private insurance premiums might occur if, for example, healthcare costs rise more rapidly than calculated, the life expectancy of privately insured persons increases more sharply than expected, or returns on investment are lower than originally assumed.

Under the Act Promoting Competition among Statutory Health Insurance Institutions *(GKV-Wettbewerbsstärkungsgesetz),* private health insurers were obligated to offer all current or former holders of private health insurance a basic tariff from 2009. This legislation also gave people voluntarily insured under the statutory scheme a one-off right, limited to six months, to switch to this private tariff.[1] A general obligation to hold insurance that was introduced at the same time was designed to avoid people being financially overburdened in the event of illness by choosing not to have insurance cover. The basic tariff must offer benefits, as would also be provided by (statutory) health insurance institutions, at a price that is no higher than the maximum contribution to the statutory health insurance scheme (currently €628 per month).[2] Including spouses or civil partners, the upper limit for the insurance premium is one-and-a-half times the maximum contribution to the statutory health insurance scheme. The contribution must be halved for people in need of social assistance[3] – and the resulting costs spread among all private insurance scheme members. A compensation mechanism among private insurers was set up to eliminate incentives to adopt a risk selection policy. Any grants from social welfare offices or employment agencies for the remaining half of the contribution must not exceed the contributions that are paid for recipients of unemployment benefit II.[4] Up until 2012,

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1 In general, this Act made it more difficult to switch from the statutory to a private health insurance scheme because, from 2006, one year with an income above the compulsory insurance limit was no longer sufficient; instead, this limit had to be exceeded for three consecutive years. This rule was repealed with effect from 1 January 2010 by the Statutory Health Insurance Financing Act (GKV-Finanzierungsgesetz).

2 The "standard tariff" that private insurers already had to offer before the Act came into force, and which was identical in terms of price and benefits, could only be selected by over-65s. The maximum amount is calculated by multiplying the general contribution rate to the statutory health insurance scheme by the maximum level of earnings subject to contributions plus the average additional contribution or, from 2015, plus the maximum special contribution.

3 As defined in the Second Book of the Social Security Code (SGB II) (unemployment benefit II) or the Twelfth Book of the Social Security Code (SGB XII) (social assistance).

4 For recipients of unemployment benefit II, until the end of 2014 one-thirtieth of 0.345 times the monthly reference figure (average wage of all persons insured in the statutory pension insurance scheme in the calendar year before last, currently €2,765 in western Germany and €2,345 in eastern Germany) will be used daily as the basis of assessment for the contribution to the statutory health insurance scheme. The Act Improving the Financial Structure and Quality of the Statutory Health Insurance Scheme (GKV-Finanzstruktur- und Qualitäts-Weiterentwicklungsgesetz) has scaled back the basis of assessment to 0.206 times the monthly reference figure, switched from daily to flat-rate monthly assessment bases, and abolished the priority given to family co-insurance, all with effect from 2015.

the proportion of people insured under the basic or standard tariff was still below 1% of all fully insured persons in a private health insurance scheme.

The basic tariff also created an option to transfer provisions for increasing age between insurers. People who have joined a private health insurance scheme since 2009 have since then been able to transfer their provisions, calculated on the basis of the average for their tariff, to a new insurer to the extent that they would accrue if they had been insured under the basic tariff throughout. Longstanding customers (who joined the insurer before 1 January 2009) were given a one-off transfer option, limited to six months, to switch to the basic tariff of another provider.

As a result, competition between private health insurers for existing customers remains limited because the provisions for increasing age are only partly transferrable. The key problem lies in determining the size of the provisions to be transferred, which were calculated on the basis of the risk assessment when the insurance policy was taken out. The option of transferring a provision calculated based on the average of the relevant risk category to another insurer would make it attractive for persons whose health risks are verifiably relatively low to switch to a new provider with lower provisions or lower insurance premiums. The result would be competition between insurers for "good risks", which could undermine their insurance function. In the statutory health insurance scheme, the risk structure compensation scheme was set up with the precise aim of avoiding this kind of competition. The total remaining provisions would then no longer be sufficient for the "bad risks", meaning that the scheme losing the customer would need to increase premiums.[5]

5 See Federal Ministry of Health and Social Security, Nachhaltigkeit in der Finanzierung der Sozialen Sicherungssysteme, Bericht der Kommission, Berlin 2003, p 169.

the weaker growth of income subject to contributions. The health insurance institutions' average contribution rate consequently rose from 14.3% in 2003 to 14.9% in 2008. A uniform contribution rate was introduced for all health insurance institutions in 2009. This was initially fixed at 15.5%[8] but was soon cut to 14.9% in mid-2009 to boost the economy and was not put back up to 15.5% until the start of 2011. In the period under review, the statutory health insurance scheme's revenue base, with an average annual growth rate of just under 2%, grew less than both total gross wages and salaries and GDP (+2½% in each case).[9]

Reserves built up due to unexpected favourable development, but trend already in reverse

The large reserves were built up principally in 2011 and 2012, when surpluses of around €9 billion were recorded in both years. Yet this was not the result of deliberate planning but instead resulted from a far better-than-expected financial development (see the box on pages 36 and 37). However, this trend appears to be reversing during the current year, not least given spiralling spending growth of 4% to 5%. As income subject to contributions is highly unlikely to keep pace with such a rapid expenditure trend, this will necessitate either higher contribution rates or renewed discretionary restrictions on benefits.

Measures to keep spending in check

Repeated intervention on the expenditure side

The statutory health insurance scheme is inherently subject to strong expenditure growth dynamics. For one thing, healthcare is a prized good in an affluent and ageing society. For an-

8 Of this total, 14.6% was apportioned equally between employers/the statutory pension insurance scheme and employees/pensioners, and 0.9% was payable by members alone as a special contribution.
9 Sluggish growth in pension benefits also played a part in this negative decoupling. Another factor was net migration of members from the statutory scheme to private health insurance companies, although per se this factor also curbed spending growth.

Financial relations between the health insurance fund and statutory health insurance institutions

The manner in which the statutory health insurance scheme is financed was restructured in 2009. While the statutory health insurance institutions' expenditure was previously financed using members' contributions and *pro rata* central government grants collected by the institutions themselves, in 2009 a fund was set up to pool these receipts and subsequently distribute them to the health insurance institutions. At the same time, it was decided that contribution rates would no longer be fixed by the health insurance institutions individually; instead, a uniform contribution rate would be set by law. This currently stands at 14.6% plus 0.9% to be paid solely by members as a special contribution, which makes a total of 15.5%. Furthermore, individual health insurance institutions were granted the right to charge their members an institution-specific, flat-rate additional contribution. However, this additional contribution will be abolished from 2015. In its place, the health insurance institutions will then be able to set an institution-specific, income-related membership contribution, which will replace the current uniform special contribution paid by members (0.9%).

The institutions' (standardised) spending needs for a given year are forecast in advance by a group of statutory health insurance estimators[1] and fixed accordingly by the German Federal Insurance Authority. Provided the projected receipts are sufficient, the health insurance fund transfers this amount to the health insurance institutions in equal monthly instalments. As a general rule, the maximum amount is calculated according to the fund's current revenue. It is therefore possible that expenditure by health insurance institutions could exceed receipts. Monthly instalments are composed of a basic flat rate per member together with premiums and discounts based on the age and gender distribution of members. Furthermore, premiums are awarded for persons with reduced earning capacity and to compensate the follow-up costs associated with particularly serious illnesses ("morbidity-oriented risk structure compensation scheme"). Finally, there are also transfers to cover the average administration costs per insured person.

Should the health insurance fund's revenue deviate from its expenditure, surpluses are paid into a reserve or deficits are offset by using this reserve. The fund's reserve should contain at least 20% of its average monthly expenditure (this currently equates to just under €3½ billion). The health insurance fund carries the risk of unforeseen receipt-related developments during the year, as payments to the health insurance institutions are fixed in advance.[2] Should contribution receipts be higher than expected, this will result in the fund recording a more favourable financial balance – and *vice versa.*

Conversely, the health insurance institutions could be affected by unforeseen developments, particularly on the expenditure side, as payments from the fund are fixed. If actual expenditure is lower than expected, the estimated financial balances will be more favourable – and *vice versa.* As a general rule, the health insurance institutions also have offsetting reserves; however, the additional contribution means that a response parameter is available in the event of stronger or sustained deviations.

Thus, the projections made by the official estimators regarding the statutory health insurance system's revenue and expenditure

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1 In addition to the German Federal Insurance Authority (Bundesversicherungsamt), the Federal Ministry of Health (Bundesministerium für Gesundheit) and the National Association of Statutory Health Insurance Funds (Spitzenverband Bund der Krankenkassen) also belong to this group of statutory health insurance estimators.

2 An adjustment to reflect actual membership figures and member distribution among the health insurance institutions takes place after the end of each calendar year. The total amount transferred from the health insurance fund remains unaffected by this, however.

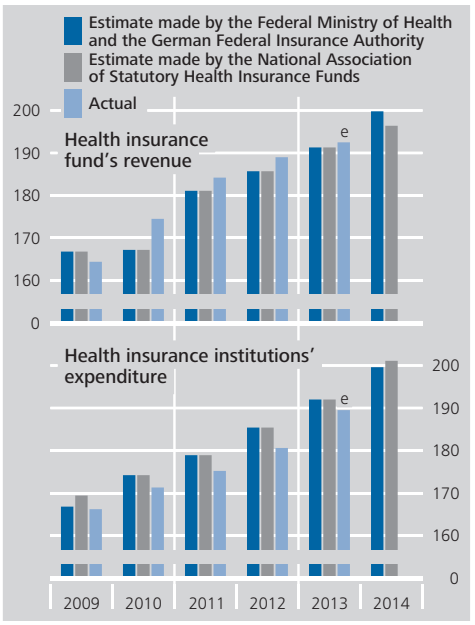
influence the financial situation of both the fund and the health insurance institutions.

The health insurance fund's receipts and the bulk of the health insurance institutions' expenditure were estimated for the first time in October 2008 for 2009. Contribution receipts had thitherto been largely understated, while spending on administration and benefits had always been overestimated. Admittedly, the autumn 2008 forecast failed to predict the magnitude of the following year's economic slump. However, economic recovery was regularly assessed too pessimistically over the period that followed. In terms of expenditure, the estimators were unable to reach a unanimous verdict for the first estimate in autumn 2008. This estimate was of particular significance because, at that time, the focus was also on determining the general contribution rate required to cover 100% of expenditure. It was ultimately set by law at 15.5% in accordance with the lower expenditure estimate made by the Federal Ministry of Health and the German Federal Insurance Authority. Seen from today's perspective, even this rate proved to be excessive, but it nevertheless initially led to the health insurance fund recording a deficit in the crisis year of 2009 (however, owing to delayed payments, the fund was not dependent on receiving central government liquidity assistance). A contribution rate of 15.8% would have been necessary based on the even higher estimate made by the health insurance institutions, which would have seen surpluses pushed up by just over €3 billion per subsequent year.

Expenditure was then unanimously overestimated for the years 2010 to 2013. This resulted in substantial surpluses for the health insurance institutions, which kept the need to charge flat-rate additional contributions within narrow bounds. Unexpectedly favourable employment and wage developments in the same period led to high surpluses for the health insurance fund, too. Moreover, the transfers to the health insurance institutions would have been set at a higher level in 2010 if the revenue trend had not been underestimated.

Estimates and actual financial development of the statutory health insurance scheme

€ billion

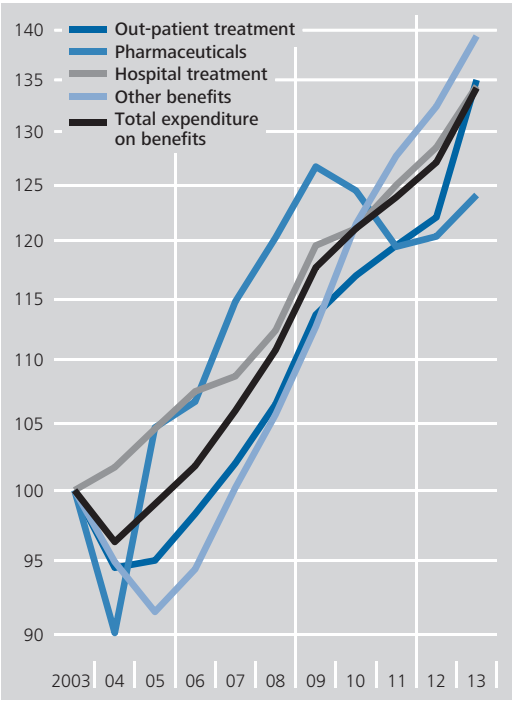


Source: German Federal Insurance Authority and Bundesbank calculations.
Deutsche Bundesbank

For 2014, it was once again not possible to reach a consensus on the estimate. On the revenue side, the Federal Ministry of Health and the German Federal Insurance Authority accounted for the political declarations of intent to cut the central government grant by €3.5 billion to €10.5 billion in 2014. By contrast, in the absence of legal clarification, the health insurance institutions continued to expect the statutory amount of €14 billion. In addition, the health insurance institutions anticipated a €1½ billion higher rise in expenditure than the other statutory health insurance estimators. Ultimately, transfers from the health insurance fund were fixed based on lower expenditure estimates made by the Federal Ministry of Health in agreement with the Federal Ministry of Finance pursuant to section 242a (2) of the Fifth Book of the Social Security Code. The impact of the cut in the central government grant was neutralised for the health insurance institutions by drawing on the health insurance fund's financial reserves.

Expenditure of the statutory health insurance scheme

2003 = 100, log scale



Sources: Federal Ministry of Health (KJ1 statistics) and Bundesbank calculations.
Deutsche Bundesbank

other, the insurees' low cost discipline and the service providers' strong bargaining position exert little pressure to improve systemic efficiency. Furthermore, advances in medical technology tend to continuously push up prices. In response to this, parliament continually amends healthcare legislation in an effort to keep the rise in spending by the statutory health insurance scheme in check (see the annex on pages 47 to 50). Over the past decade, such legislative intervention focused on spending on pharmaceuticals as well as on in-patient and out-patient treatment.

Mandatory discounts and critical evaluation of new pharmaceuticals

The measures to curb the rising cost of pharmaceuticals centred on temporarily raising the mandatory discounts on the prices charged by manufacturers and retailers (including pharmacies) and attempting to price new, patented pharmaceuticals that are generally excluded from the list of fixed prices (a *de facto* price ceiling) according to their actual benefits. Even though co-payments[10] for insurees were repeatedly increased and the manufacturer's discount for prescription pharmaceuticals was raised from 6% to 16% as a one-off measure in 2004, expenditure growth in the subsequent years was still way above average, and so the manufacturer's discount had to be put back up to 16% on 1 August 2010.[11] Furthermore, a price moratorium was imposed, fixing prices at the level of 1 August 2009. Health insurance institutions were also able to negotiate additional institution-specific discounts with manufacturers of pharmaceuticals. As a result, these measures enabled growth in expenditure on pharmaceuticals to be kept to just over 2% per annum on average between 2003 and 2013, which was distinctly below the overall rise in spending on benefits (+3%). However, following the expiry of the higher discounts, spending growth has begun to clearly accelerate of late.

Spending on hospitals curbed by fewer beds and shorter stays

In the period under review, spending on hospitals rose at an average annual rate of 3%, in line with total spending on benefits. This was accompanied by a 1% decline in the number of hospital beds each year between 2003 and 2012, whereas the number of patients concurrently rose by almost 1% per year. This was due to the fact that the average hospital stay was shortened by just over 1½% per year (from 8.9 days in 2003 to 7.6 days in 2012).[12] Even though declining rates had been recorded previously, this reduction probably owed much to the wholesale replacement of daily nursing charges by categorised lump-sum payments as

10 Co-payments are treated here not as revenue but as negative expenditure.
11 The legislation stipulates a general (bulk purchase) discount for pharmaceuticals in favour of the health insurance institutions. As of 2014, this was raised permanently from 6% to 7%.
12 See Federal Statistical Office, Grunddaten der Krankenhäuser, Wiesbaden 2014.

of 2004.[13] There were also additional government intervention measures, which brought both cost relief and extra charges for the health insurance institutions. In addition, the Act Promoting Competition among Statutory Health Insurance Institutions obliged hospitals to grant health insurance institutions a 0.5% discount on treatment billed as of 2006. However, this discount was discontinued in 2009 with the Act Reforming Hospital Financing, and hospitals were also granted additional funds in 2008 and 2009, in particular to cover half of the rises in negotiated rates of pay where these exceeded growth in wages subject to contributions. While the Statutory Health Insurance Financing Act eased the financial strain on health insurance institutions as of 2011 by prescribing discounts on supplementary benefits exceeding the contractual agreements, hospitals were given another boost in 2013, in particular in the form of treatment surcharges.

Changeover of doctors' remuneration system resulted in additional expenditure

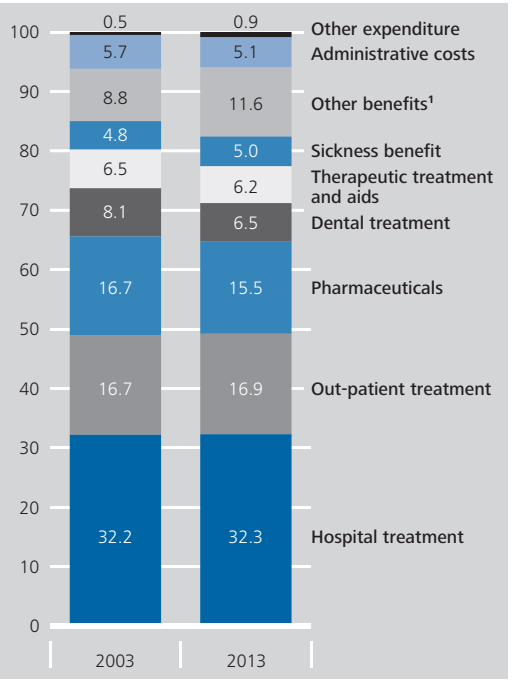
The Act Promoting Competition among Statutory Health Insurance Institutions changed the system for remunerating out-patient treatment as of 2009 from point values, which enabled strict budgeting pegged to the development of income subject to contributions, to fixed diagnosis-related prices. An expansion of supply beyond the volume actually required was to be prevented by regressive remuneration as soon as the standard volume of treatment is exceeded. Overall, however, expenditure still accelerated rapidly in 2009. Spending surged again in 2013 by almost €2 billion following the abolition of the surgery visit charge of €10 per quarter, which was introduced in 2004. All in all, spending on out-patient treatment rose at an annual average of 3% between 2003 and 2013.

Above-average growth in spending on other benefits

At almost 3½%, spending on the other benefit categories expanded at an above-average rate. Home nursing and transportation expenses recorded particularly high growth. Spending on sickness benefit initially declined during the period under review but has been increasing considerably since 2007. According to information from the Federal Ministry of Health, sickness benefit is predominantly claimed by older insurees in paid employment.[14] It is thus possible that sickness benefit is being partly misused as a substitute for early retirement after the early retirement options previously offered by the statutory pension insurance scheme have been progressively phased out.

Expenditure structure of the statutory health insurance scheme

%



Sources: Federal Ministry of Health (KJ1 statistics) and Bundesbank calculations. **1** In particular home nursing, travel expenses, rehabilitation and preventive measures.
Deutsche Bundesbank

13 Hospital funding is dualistic, with state governments being responsible for financing investment whereas the health insurance institutions have to cover hospitals' current expenditure on treatment. At the same time, the remuneration system was gradually switched over from full cost coverage by means of daily nursing charges to categorised lump-sum payments for each defined treatment, which eliminated the incentive to keep patients in hospital beds for longer than necessary. The categorised lump-sum payments are annually updated by a joint committee representing the health service institutions and the medical profession.

14 See Federal Ministry of Health, Press release No 30 of 19 June 2014.

Selected aspects of the discussion on the statutory health insurance scheme

Changes to the funding system

Funding system subject of fundamental discussion

In the wake of the last major health benefits reform in 2004 (by virtue of the Act Modernising the Statutory Health Insurance Scheme), the primary focus not only of the expert discussions but also of the actual healthcare policy has in recent years been the financing structure of the statutory health insurance scheme. The reform proposals mostly focused on the extensive income redistribution effects within the health insurance scheme, which are relatively opaque and unselective.

"Citizens' insurance model" vs …

The advocates of a "citizens' insurance model" would like to broaden the funding base by extending both the range of income subject to contributions and the group of compulsorily insured persons. They would like to expand the current contribution base, which almost exclusively comprises primary or secondary labour income (such as state or company retirement pension benefits), to include additional income streams such as income from investments, renting or leasing. Furthermore, the group of compulsorily insured persons would be widened to include public sector employees with civil servant status, the self-employed and higher paid employees. Innumerable permutations of this basic idea are conceivable. The idea boils down to applying a lower contribution rate to a broader contribution base. While the additional positive income that would be subject to contributions would definitely have a favourable impact on the scheme's finances, the additional insurees will not only generate higher revenue but also give rise to higher expenditure. The citizens' insurance model would leave little scope for a full-cover private health insurance scheme, which mostly pays considerably higher rates for treatment; private health insurers could then merely offer supplementary cover for extra benefits not provided under the citizens' insurance model. The income redistribution function within the statutory health insurance scheme would be expanded further by including additional types of income and groups of insurees.

… healthcare premiums model

The rival "healthcare premiums model" based on flat-rate contributions is aimed at shifting the income redistribution function to the actual tax and transfer system. Within each individual health insurance institution, each member would pay exactly the same amount for identical insurance protection.[15] However, to ensure effective competition, the institutions would be able to set their own premium. The specific proposals for implementing this model vary *inter alia* with regard to whether co-insured persons who have so far been exempt from contributions should pay a (full) healthcare premium. In particular, there are also discussions regarding the precise form that the social compensation component should take so that persons in lower-income groups are not overburdened in socio-political terms. Another outstanding issue is how the social compensation component would be funded. Suggestions include putting up VAT rates or raising the solidarity surcharge.[16] The proponents of this model highlight the fact that it would ensure a more focused and transparent social compensation component and thus enable the burden resulting from unselective taxes and social contributions to be reduced overall.[17]

Rather than adopting these rather radical reforms, the policymakers decided to make grad-

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15 For the wage substitute sickness benefit (70% of previous gross earnings, but no more than 90% of previous net earnings once the six-week period of continuing entitlement to pay has come to an end) these concepts mostly envisage separate insurance to be financed via income-related contributions in line with the principle of equivalence between contributions and benefits.

16 See Deutsche Bundesbank, Financial development and outlook of the statutory health insurance scheme, Monthly Report, July 2004, pp 27 ff.

17 The German Council of Economic Experts presented the "citizens' flat rate" model as a compromise solution. It combines elements from both models, taking the concept of extending the group of insurees from the citizens' insurance model and the flat financing principle from the healthcare premiums model. See German Council of Economic Experts, Jahresgutachten 2004/05, sections 485 ff.

Health insurance fund as interim solution

ual changes. The introduction of the health insurance fund in 2009 was a first step, without the ultimate goal already being set in stone. Since then, the health insurance institutions pass on the contributions they collect to the health insurance fund, which, in turn, transfers insurance premiums per member to the health insurance institutions. These premiums no longer reflect the level of contribution income, but only the schematically calculated health risks of the insurees at the respective institution. In this context, the risk structure compensation scheme between the health insurance institutions has also been overhauled. Whereas before only gender, age and reduced earning capacity were taken into consideration, the risk structure compensation mechanism now also includes a morbidity-oriented component that takes account of the dispersion and costs of 80 medical conditions (see the box on pages 36 and 37). The previous income compensation mechanism across the health insurance institutions, whereby money was transferred from those institutions with members on above-average wages to those with members on below-average wages, has been made obsolete by the health insurance fund.

Initial limited flat additional contribution …

Since 2009, a uniform contribution rate has been set by law. As of then, differing contributions charged by the individual health insurance institutions – which is important for competition – have been achieved by means of flat-rate additional contributions per insured person (or also via premium paybacks to insurees). However, these were initially capped at 1% of an individual's income subject to compulsory insurance contributions. For the sake of simplicity, the additional contribution did not have to be means-tested if it did not exceed €8 a month. The health insurance institutions received the additional contributions directly from their members. Nevertheless, it was envisaged that the health insurance institutions as a whole would continue to meet at least 95% of their overall expenditure needs through payments from the health insurance fund and thus via the general contribution rate – which would have to be adjusted if necessary.

… extended towards unlimited flat additional contribution, …

The Statutory Health Insurance Financing Act, which entered into force in 2011, constituted a further step towards a healthcare premiums system. It scrapped the cap on the flat additional contribution. In future, the uniform income-related percentage contribution rate would be left unchanged and any additional funding needs of the health insurance institutions would be met entirely by means of the additional charge. The social equalisation component for individual members envisaged lowering the employee's contribution share (to be ultimately financed out of the central government budget) if the average additional contribution measured across all health insurance institutions exceeded the maximum level of 2% of the individual's income subject to compulsory insurance contributions. Taking the average amount and not the institutions' actual additional contribution as a benchmark meant that there was still an incentive for members to switch to a different provider with a lower additional contribution.

… but has virtually not been applied

The average additional contribution was projected *ex ante* by the official estimators by comparing the health insurance institutions' forecast expenditure per member with their revenue per member. To date, however, there has been no average need for additional contributions as the transfers from the health insurance fund have always sufficed – also *ex post* – to cover the institutions' total expenditure. Nevertheless, individual institutions have had to charge additional contributions to plug gaps in their budgets. Some of those institutions that did levy an additional contribution consequently lost a substantial number of members. The resultant pressure on health insurance institutions to avoid levying additional contributions by finding alternative measures is likely to have encouraged them to identify and realise cost-efficiency reserves (including achieving scale effects through mergers).

Recent changeover to income-related additional contribution

By virtue of the Act Improving the Financial Structure and Quality of the Statutory Health Insurance Scheme, which was adopted in June 2014, the flat additional contribution will be abolished as of 2015 and replaced by an income-related special contribution, likewise to be paid solely by the members. This builds on the existing structures. For one thing, the general contribution rate, to be shared equally between employer and employee, is fixed at 14.6%. For another, the income-based special contribution replaces the additional contribution of 0.9% paid up to now by members alone.[18] Given the health insurance institutions' extensive reserves, the future special contribution rate might initially be lower on average than the previous general extra contribution component. However, it is to be expected that the rate will be put up again in future years as healthcare spending is set to continue to rise at a faster pace than insurees' income subject to compulsory insurance contributions.

Move towards shifting redistribution function to tax and transfer system halted

Overall, the recent reform backtracks on the steps taken towards a healthcare premium, and a relatively opaque and unselective income redistribution mechanism remains a typical feature of the statutory health insurance scheme. This halts the envisaged partial shift of the income redistribution mechanism to the tax and transfer system from 2015 onwards, with the plan to finance the costs of the social equalisation component from the central government budget once the health insurance fund's reserves had been depleted.[19] The abandonment of the healthcare premiums model could result in less intensive competition between the institutions because the method of levying the additional contribution will now be less transparent. By contrast, it is likely that private health insurance companies, with their non-income-related premiums, will in future be a more attractive option for those whose income is above the threshold for opting out of the statutory health insurance scheme.

The legal stipulation of a uniform general tax rate as of 2011 means that employers no longer pay half of any contribution rate increases, and their direct funding share is likely to decrease in future.[20] This could lessen their interest in demanding moderate expenditure growth as they are no longer directly affected. However, the greater contribution burden now placed on employees will ultimately have at least a partial knock-on effect on employers via future higher wage demands.

Employers shielded from rising contribution rates

Unsteady course of healthcare policy over past decade

It is clear that over the past decade much has been done, both on the expenditure and revenue side, to stabilise the finances of the statutory health insurance scheme. These steps have proven successful insofar as the scheme's debt has been reduced and extensive reserves have been built up. This is primarily attributable to the fact that central government grants and contribution rates were raised more than was actually necessary to fund current expenditure. Overall, however, the measures that have been taken do not point to consistent, forward-looking aims in healthcare policy. For instance, discounts on pharmaceuticals have been raised on numerous occasions only to be cut again, hospital financing has seesawed, and the surgery visit charge was introduced and then abolished. Similarly, the funding system was initially changed towards a healthcare premium, but has recently more or less ended up back where it started. Policymakers apparently attached little importance to the advantages of aligning

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18 In addition, the special contribution is subject to a comprehensive cross-institutional income equalisation scheme, which is aimed at preventing institutions with members on below-average wages being put at a disadvantage. To this end, the health insurance fund will initially collect the special contributions on behalf of the individual health insurance institutions and then pass on the average special contribution per member that would have been collected if the rate set by the respective institution had applied throughout Germany.

19 Prior to the recent reform, central government had factored in a burden of just over €½ billion from 2015 onwards in its budget plans. Even if these estimates meanwhile appear excessive for the initial phase, the central government budget would have been confronted with far larger burdens in the foreseeable future based on the statutory health insurance scheme's strong expenditure growth.

20 The same applies to the statutory pension insurance scheme, which is thereby shielded from co-funding excessive expenditure increases in the statutory health insurance scheme.

contributions and benefits more closely through healthcare premiums or to achieving a more transparent income redistribution mechanism. It is likely that their decisions were influenced by resistance to disclosing the distribution flows and, in particular, by the foreseeable costs of the social equalisation component for the central government budget.

Financial relations between the statutory health insurance scheme and the central government budget

Contribution system important feature of the overall social security system

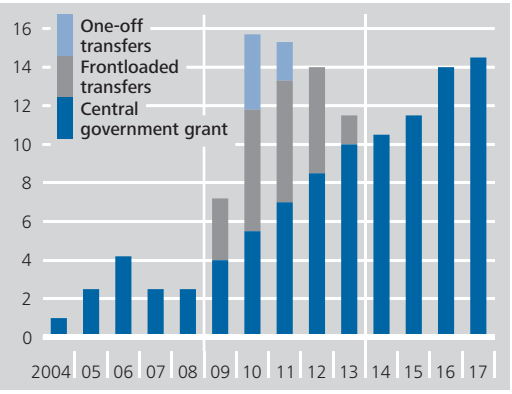
In Germany, in principle, you must be a member of the social security system and pay contributions in order to be eligible to receive social benefits. In the case of the statutory pension insurance scheme and the unemployment insurance scheme, there is a relatively strong degree of contribution equivalence, as the level of benefits received largely reflects the level of contributions paid. However, as explained above, there is not such a close degree of contribution equivalence in the statutory health and public long-term care insurance schemes. Furthermore, the statuary health insurance scheme also provides certain general societal or non-insurance-related benefits. To ensure that such extraneous benefits are not funded by members' contributions but rather are fairly financed by the broader group of taxpayers, the costs of such tasks would need to be covered using general tax revenue (which is, in principle, not earmarked for specific uses), eg through central government grants specifically allocated to this purpose.

Flow of central government grants rather erratic

The central government grant was introduced for the first time in 2004 by the Act Modernising the Statutory Health Insurance Scheme. It was planned to raise it over time from an initial amount of €1 billion to €4.2 billion from 2006 onwards. The justification given for the grant was that it would provide global reimbursement of non-insurance-related benefits. It was intended to cover, in particular, benefits provided by the health insurance institutions that are not strictly speaking linked to illness (especially pregnancy and maternity benefits). However, the grant was quickly lowered again in 2007 to €2.5 billion in order to provide short-term relief for the central government budget. Under the Act Promoting Competition among Statutory Health Insurance Institutions the grant was then raised significantly. The original concept behind this was to finance the non-contributory co-insurance of children out of general taxation. A target of €14 billion per year was set for the central government grant, which would be reached by increasing the grant by €1.5 billion each year, thereby achieving the goal in 2016. Extensive economic stimulus packages were then launched in the wake of the economic crisis in 2009, which included reducing social contributions. In order to offset the revenue shortfalls arising from the 0.6 percentage point cut in the contribution rate, planned increases in the central government grant were brought forward. Moreover, in 2010 and 2011, one-off additional transfers of €4 billion and €2 billion, respectively, were made to compensate for cyclically induced revenue shortfalls. Consequently, the central government grant peaked at €15.7 billion in 2010 and then dropped back down to its long-term target of €14 billion by 2012. The exceptionally favourable development of the statutory health

Central government grants to the statutory health insurance scheme*

€ billion



* Grants from central government pursuant to sections 221 and 221a of the Fifth Book of the Social Security Code.

Deutsche Bundesbank

insurance scheme's finances thereafter was evidently once again seen as a means to potentially reduce central government funding without having to put up contributions. The grant was therefore cut by €2.5 billion to €11.5 billion in 2013. Under the Act Accompanying the 2014 Budget, the grant is being scaled back further in 2014 to €10.5 billion. For the years thereafter, the grant is set to be put up to €11.5 billion, then €14 billion, reaching the new target of €14.5 billion from 2017 onwards. The temporary revenue shortfall caused by the recent cuts is to be offset by drawing on the financial reserves of the health insurance fund, so that the health insurance institutions will not be hit by lower transfers.

Central government grant should be earmarked for specified non-insurance-related benefits

The rather erratic adjustments to the central government grant to the statutory health insurance scheme are likely to have been driven not least by central government's budgetary goals. The grant's vague budget appropriation, namely to reimburse unspecified non-insurance-related benefits, provides little scope for assessing and checking its appropriateness. It would therefore make sense to draw up a specified list of the statutory health insurance scheme's general societal tasks that are to be financed via general taxation. To this end, parliament should first of all define the core tasks of the statutory health insurance scheme (to be financed through contributions), and then list the tasks that do not fall within this remit and are thus non-insurance-related tasks. Even if individual cases may be open to dispute and a certain amount of discretionary scope remains, a defined list of benefits, together with specified allocation of the grant, would provide a more transparent basis for discussing central government grants. This would give the statutory health insurance scheme greater planning certainty and would avoid giving the impression that funding is changed at the government's whim to suit the respective budgetary situation.

While it may be appealing to policymakers to factor in a certain amount of leeway in the central government budget through the discretionary tailoring of central government grants, this has a detrimental impact on the statutory health insurance scheme's budgets, which are ultimately also financed through compulsory payments. It would therefore seem advisable to calculate the grants to the statutory health insurance scheme on the basis of the tasks that it has to perform, and to directly plan in any budgetary leeway deemed necessary in the central government budget. The budgetary surpluses that this would often generate would, moreover, be useful for scaling back central government's high level of debt.

Budgetary leeway should not be concealed in social security scheme

Outlook and challenges

Depletion of reserves foreseeable

At first glance, the statutory health insurance scheme's finances currently look favourable, after once again recording a surplus in 2013 and with cumulated large reserves. However, it should be borne in mind that this is only a temporary phenomenon and that the financial pressure on the scheme is set to increase again. Health services are likely to become increasingly significant in future, not only because of the ageing population, but also due to a generally rising demand. The knock-on effect of this on the statutory health insurance scheme, if the contribution rate remains unchanged, will be to place an ongoing strain on the scheme's finances in future years owing to the underlying tendency for the contribution base to grow more slowly than health service spending. It is already foreseeable that the reserves of the statutory health insurance scheme will be fairly rapidly depleted. Thus a substantial deficit is on the cards for 2014, not least due to the cut in the central government grant, which is to be offset using the statutory health insurance fund's reserves. With spending pressure likely to continue unabated, the deficit is set to climb further in the coming years, even if the current plans to increase the central government grant are implemented. Consequently, additional increases in the contribution rate above its present level appear unavoidable.

Hence the scheme's currently favourable financial situation – which is both attracting the cupidity of various vested interests and weakening the resolve to curb expenditure – is merely a brief interlude, which is likely to end even before demographic factors begin to impinge on the health insurance system.

Long-term projections indicate considerable cost risks, …

The last comprehensive long-term projections for age-related expenditure in EU member states were made in 2012.[21] The projections indicate that, unless appropriate countermeasures are taken, government healthcare spending in Germany could rise perceptibly from the level of 8% of GDP in 2010, rising to between over 8½% and almost 11% up to 2060. This relatively wide projection range illustrates that the multiplicity of determinants involved make projections of spending developments in this area less reliable than, say, those for old-age pensions. This is attributable to factors on both the demand side (demographics, impact of rising pay on healthcare demand, growing health risks given higher life expectancy) and on the supply side (wage costs in the healthcare sector, cost-driving advances in medical technology). Other key determinants are how the statutory health insurance scheme's range of benefits (including co-payments) will be defined in future and whether benefits will be rationed (by expenditure). The spending curve might be relatively flat if the number of years in which health services are drawn on massively were to remain constant on average despite the population's rising longevity – ie if all the extra years "gained" tended to be spent in good health. By contrast, the healthcare spending ratio could rise particularly sharply if the phase during which more intensive medical care is needed turns out to be prolonged and, moreover, advances in medical technology drive up costs.

… which could push up contribution rates accordingly

The forecast expenditure increases point towards a significantly higher contribution burden in future years. The EU projections suggest that the contribution rate would have to rise to somewhere between 16½% and 21½% by 2060. In combination with the other age-related expenditure on pensions and long-term care, as well as in connection with unemployment, the aggregate social contribution rate for the overall social security system could thus end up in a range of around 47½% to 54½% (compared with the current figure of 39½%). Unlike pension expenditure, for example, which is limited by the falling pension level factored into the adjustment formula, there are no comparable rules-based moderating factors for healthcare spending. Instead, it is subject to frequent legislative interventions in benefit and remuneration rates, which may be expected to continue as accrued health entitlements are less clear-cut than accrued pension entitlements, for instance. However, such measures can only be accounted for in the projections by means of highly uncertain guestimates.

Moral hazard promotes excessive demand for health services

On the one hand, the expected rising growth trend for healthcare expenditure will tend to reflect insurees' preferences, but also on the other hand, a supply-induced boost in demand, which, in turn, is facilitated by a lack of transparency in this specific market. An insurance scheme under which insurees receive benefits largely without having to pay the treatment bill or even knowing exactly what costs have been invoiced is inherently vulnerable to being used excessively, especially if health service providers are able to exert a strong influence on demand.

Options for curbing expenditure: greater transparency and higher co-payments

These fundamental insurance-related problems can be mitigated using various instruments, which could be applied even more intensively in the statutory health insurance scheme. One starting point would be to provide greater transparency for patients over billed treatment and costs. Transparency could be enhanced, for example, by a (partial) changeover from the principle of non-invoicing patients to the prin-

21 See European Commission (DG ECFIN) and Economic Policy Committee (AWG), The 2012 Ageing Report: Economic and budgetary projections for the 27 EU Member States (2010-2060), Joint Report, in: European Economy 2/2012. In this context, government healthcare spending includes, in particular, the expenditure of the statutory health insurance scheme and civil servant subsidies.

ciple of cost refunding. Although all persons insured under the statutory health insurance scheme can opt for cost refunding, in reality this option is barely used, which is understandable given the lack of incentives for individual insurees. Deductibles, assumption of part of the costs and contribution refunds can also help prevent excessive use of the scheme. These instruments already form part of the legislation governing benefits and were extended, in particular, by virtue of the Act Promoting Competition among Statutory Health Insurance institutions in 2007, which gave health insurance institutions scope to offer different premiums to suit insurees' individual needs. A cost-income cap is intended to prevent households from actually being overburdened by these co-payments.[22] However, with the abolition of the surgery visit charge in 2013, policymakers changed track once again.[23] Generally speaking, the (political) implementation of such co-payments is hampered by the fact that the disadvantages, for both service providers and co-paying patients, are immediately apparent, whereas the advantages of a lower financial burden are widely dispersed. There still seems to be scope for creating greater transparency between the demand and supply sides of the healthcare system (for example, via the insurance card or internet portals) and for improving medical treatments through a more consistent analysis of the available data.

Flat financing could return to the agenda

The dropping of the flat additional contribution, which constituted a step towards the healthcare premiums model, meant that the twin goal of getting health insurance institutions to openly display their costs and of more precisely steering the redistribution effects within the scheme's funding structure was likewise abandoned. There is thus still scope for curbing the burden of distorting and therefore growth-impairing government levies. It remains to be seen whether the scheme's funding system will be the subject of renewed debate going forward once economic and, in particular, demographic turbulence is encountered and pressure to raise contribution rates mounts. Irrespective of this, non-insurance related benefits should be transparently itemised and refunded from out of the central government budget.

Capital funding not fundamental solution to financing problem, recent pension reform step in wrong direction

As the statutory health insurance scheme is financed without actuarial reserves under the pay-as-you-go system, the looming demographic changes will impact on both the revenue side (via a narrower contribution base) and in all likelihood also on the expenditure side (via a growing share of older insurees). A capital-funded system, with provisions for increasing age, would be less exposed to these changes. However, a systemic changeover of the funding system would subject members to double burdens during a transitional period, as, in addition to current expenditure, they would also have to fund the accumulation of a capital stock. A collective reserve, as envisaged in the public long-term care insurance scheme, permits redistribution between different age cohorts. However, this presupposes not least that policymakers cannot misuse the reserve for other purposes. With regard to demographic trends, it will be important to stabilise the funding base, which will be weakened by an ageing population. In this context, it would make sense to continually adjust the statutory retirement age to increasing life expectancy. By contrast, recently adopted legislation, particularly concerning the ability of certain social groups to claim a full pension without actuarial deductions at the age of 63, encourage early retirement and are therefore a step in the wrong direction, including from the perspective of the statutory health insurance scheme.

22 Under the current legislation, co-payments made by a member (and any co-insured persons) are not to exceed 2% of the household's annual gross income. The payments are capped at 1% for persons who are chronically ill (section 62 of the Fifth Book of the Social Security Code).
23 The quarterly surgery visit charge was intended to address the above-average frequency of visits to the doctor in Germany, based on the assumption that such co-payments would increase insurees' cost awareness and thus tend to dampen demand.

Annex

Major legislative changes concerning the financing of the statutory health insurance scheme[24]

Act Improving Cost Efficiency in Pharmaceuticals Supply *(Gesetz zur Verbesserung der Wirtschaftlichkeit in der Arzneimittelversorgung)* (2006)

Notably introduces a two-year moratorium on manufacturers' pharmaceuticals prices.

Act Accompanying the 2006 Budget *(Haushaltsbegleitgesetz 2006)* (2006)

As of 1 January 2006, the contribution base for recipients of unemployment benefit II is reduced from 36.2% to 34.5% of the monthly reference figure, while the flat statutory health insurance contribution rate for low-paid part-time workers is raised from 11% to 13%.

The Federal grant to the statutory health insurance scheme is reduced from €4.2 billion to €1.5 billion as from 2007.

Act Amending the Law Governing the Professional Activities of Doctors Approved by the Statutory Health Insurance Scheme *(Vertragsrechtsänderungsgesetz)* (2006)

The deadline for health insurance institutions to pay down their debt, which was set in 2003 by the Act Modernising the Statutory Health Insurance Scheme, is extended by one year until the end of 2008.

Act Promoting Competition among Statutory Health Insurance Institutions *(GKV-Wettbewerbsstärkungsgesetz)* (2007)

Introduces a health insurance fund on 1 January 2009, which collects contributions and passes on risk-adjusted *per capita* payments to the health insurance institutions. The fund's resources should cover at least 95% of expenditure by health insurance institutions on a permanent basis. The health insurance institutions must bridge any funding gap by charging flat additional contributions. This additional contribution may not exceed 1% of the insuree's income subject to compulsory contributions if it is set at more than €8 per month.

From 2009, the general contribution rate for statutory health insurance is set annually by the Federal Government by statutory order (without the approval of the Bundesrat) following evaluation of the forecasts of the responsible statutory health insurance estimators.

The risk structure compensation scheme is based on the morbidity rates of 80 cost-intensive chronic illnesses.

The Federal grant is set at €2.5 billion each for 2007 and 2008 and is subsequently to be increased by €1.5 billion per year up to €14 billion.

The remuneration system for out-patient treatment is switched from fixed point values, which allowed for strict budgeting, to fixed benefit fees that are adjusted downwards when standard benefit volumes are exceeded.

Private health insurance enterprises are obligated to offer a basic tariff that must provide the services of the statutory health insurance scheme at a price no higher than its average maximum contribution. For persons claiming social assistance, the insurance premium is to be halved at the cost of all private insurance scheme members.

The income threshold for switching to a private health insurance scheme, ie a level of income above the compulsory insurance limit, has to be met not just in one year but in three consecutive years.

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24 This Annex presents the most important legislative changes since the Act Modernising the Statutory Health Insurance Scheme (GKV-Modernisierungsgesetz), which entered into force in 2004. For developments prior to this date, see Deutsche Bundesbank, Financial development and outlook of the public health insurance scheme, Monthly Report, July 2004, pp 15-31.

Act Adapting the Organisational Structures of the Statutory Health Insurance Scheme *(Gesetz zur Weiterentwicklung der Organisationsstrukturen in der gesetzlichen Krankenversicherung)* (2008)

The financial reporting requirements for statutory health insurance institutions are more strongly aligned with the assessment principles laid out in the German Commercial Code *(Handelsgesetzbuch).*

In particular, all health insurance institutions become eligible for insolvency from 1 January 2010 and are additionally obligated to establish adequate pension provisions for the non-contributory pension entitlements of their staff with civil servant status by 2050.

Regulation Establishing the Contribution Rates in the Statutory Health Insurance Scheme *(Verordnung zur Festlegung der Beitragssätze in der gesetzlichen Krankenversicherung)* (2008)

The general contribution rate is set at 15.5% as of 1 January 2009. Of this, 14.6% is to be financed equally by employer and employee and 0.9% is to be raised by members alone.

Act Reforming Hospital Financing *(Krankenhausfinanzierungsreformgesetz)* (2009)

In order to improve hospitals' financial resources, health insurance institutions are notably obligated to permanently refinance half of the collective wage increases for hospital staff agreed for 2008 and 2009 to the extent that they exceed the rate of change in average income subject to compulsory contributions that is relevant for determining remuneration.

Act Securing Employment and Stability in Germany *(Gesetz zur Sicherung von Beschäftigung und Stabilität in Deutschland)* (2009)

To offset the revenue shortfalls caused by cutting the contribution rate on 1 July 2009 (from 15.5% to 14.9%), the Federal grant for 2009 is lifted from a previously planned €4 billion to €7.2 billion, and for 2010, from €5.5 billion to €11.8 billion.

Social Security Stabilisation Act *(Sozialversicherungs-Stabilisierungsgesetz)* (2010)

Central government makes an additional Federal grant of €3.9 billion in 2010.

Act Amending Health Insurance Provisions and Other Provisions *(Gesetz zur Änderung krankenversicherungsrechtlicher und anderer Vorschriften)* (2010)

The manufacturer's discount for pharmaceuticals that are not subject to the fixed-amount regulation is raised from 6% to 16%. A price moratorium is set for pharmaceuticals paid for by the statutory health insurance scheme. Both rules apply from 1 August 2010 until the end of 2013.

Pharmaceuticals Restructuring Act *(Arzneimittelneuordnungsgesetz)* (2010)

New and innovative pharmaceuticals will now only be reimbursed at the requested price for one year. Manufacturers must have furnished proof of the additional benefit of new pharmaceuticals by then; otherwise, only the price valid in the fixed-price system will be reimbursed.

Statutory Health Insurance Financing Act *(GKV-Finanzierungsgesetz)* (2010)

The 1% cap on the flat additional contribution on income subject to compulsory contributions is rescinded. If the average additional contribution exceeds 2% of an individual's income subject to compulsory contributions in future, social equalisation occurs in the form of a corresponding reimbursement of the income-related employee or pensioner contribution. The revenue shortfalls in the health insurance fund caused by this are to be reimbursed from the Federal budget from 2015.

The general contribution rate is raised from 14.9% to 15.5% as of 1 January 2011. Rule-bound adjustment of this contribution rate is dropped.

To limit the increase in expenditure, in particular payments by the health insurance fund to health insurance institutions for administrative costs in 2011 and 2012 are frozen at the 2010 level, discounts are introduced in the remuneration of hospitals for benefits over and above the agreed volume, and the

remuneration of dentists as well as in contracts for GP-routed healthcare is limited.

The income threshold for switching to private health insurance is reduced again to just one year's earnings above the compulsory insurance limit.

Act Accompanying the 2011 Budget *(Haushaltsbegleitgesetz 2011)* (2010)

Central government transfers an additional €2 billion to the health insurance fund in 2011.

Act Restructuring Statutory Healthcare Provision *(GKV-Versorgungsstrukturgesetz)* (2011)

The system for remunerating doctors is restructured in order to ensure health services are available in structurally weak areas.

Act Amending Low-paid Part-time Employment Legislation *(Gesetz zu Änderungen im Bereich der geringfügigen Beschäftigung)* (2012)

The earnings ceiling for low-paid part-time work (for which a flat statutory health insurance contribution rate of 13%, or 5% in the case of household services, applies) is raised from €400 to €450 per month from 1 January 2013.

Act Regulating Personal Assistance Needs in In-patient Prevention and Rehabilitation Institutions *(Gesetz zur Regelung des Assistenzpflegebedarfs in stationären Vorsorge- und Rehabilitationseinrichtungen)* (2012)

The surgery visit charge of €10 per quarter that was introduced in 2004 for visits to the doctor or dentist is abolished as from 2013.

Act Accompanying the 2013 Budget *(Haushaltsbegleitgesetz 2013)* (2012)

The Federal grant to the health insurance fund for 2013 is reduced by €2.5 billion to €11.5 billion as a once-only measure.

Act Eliminating Unsustainable Burdens arising from Outstanding Health Insurance Contributions *(Gesetz zur Beseitigung sozialer Überforderung bei Beitragsschulden in der Krankenversicherung)* (2013)

The increased late payment surcharge of 5% of the overdue contributions is abolished.

An emergency tariff is introduced in private health insurance for insurees who cannot meet their contribution obligations.

Additional remuneration for hospitals and further measures to take into account hospitals' actual cost increases are adopted.

Thirteenth Act amending the Fifth Book of the Social Security Code *(13. SGB V-Änderungsgesetz)* (2013)

The price moratorium on pharmaceuticals paid for by the statutory health insurance institutions, which runs until the end of 2013, is extended until the end of March 2014.

Fourteenth Act amending the Fifth Book of the Social Security Code *(14. SGB V-Änderungsgesetz)* (2014)

The assessment of the benefits of new pharmaceuticals marketed prior to the start of 2011, which was initiated prior to the Pharmaceuticals Restructuring Act, is terminated owing to disproportionately high research and administration.

To offset this, the price moratorium on pharmaceuticals is extended until the end of 2017.

The manufacturers' discount on pharmaceuticals not subject to the fixed-amount regulation, which was reduced from 16% to 6% at the end of 2013, is increased to 7% as of 1 January 2014.

Act Accompanying the 2014 Budget *(Haushaltsbegleitgesetz 2014)* (2014)

The Federal grant to the health insurance fund is reduced by €3.5 billion to €10.5 billion in 2014, and raised again to €11.5 billion in 2015 and €14 billion in 2016. From 2017, €14.5 billion is to be transferred each year.

Act Improving the Financial Structure and Quality of the Statutory Health Insurance Scheme *(GKV-Finanzstruktur- und Qualitäts-Weiterentwicklungsgesetz)* (2014)

The flat additional contribution is abolished as of 1 January 2015, and the 0.9% additional contribution rate to be raised by the members alone can in future be set by each health insurance institution according to its funding needs. This obviates the need for the envisaged social equalisation to be funded by the Federal budget from 2015.